



Management of Respiratory Type Viruses

This procedural document supersedes: PAT/IC 10 v.10 – Management of Respiratory Influenza Type Viruses.



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Executive Sponsor(s):	Simon Brown, Deputy Chief Nurse
Author/reviewer: (this version)	Carol Scholey Infection Prevention and Control Practitioner
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Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
11		<ul style="list-style-type: none"> • Updated symptoms of Covid-19 and common respiratory infections • Updated Respiratory isolation & changes to face masks for patients • Added Staff Vaccination • Updated AGPs list • Removed MERS information • Updated UKHSA information • Updated monitoring compliance with the procedure document • Updated all hyperlinks • Added additional abbreviations • Page 9 images replaced due to copyright issues • References updated 	Carol Scholey
10	24 Sept 2021	<ul style="list-style-type: none"> • Added section on the management of severe acute respiratory syndrome coronavirus 2 (COVID-19) • Removed some hyperlinks due to data not being found 	Carol Scholey
9	22 October 2018	<ul style="list-style-type: none"> • Updated evidence • Added POCT • Updated Hyperlinks • Added Appendix 1. When to use a surgical face mask or FFP3 respirator, and removed 'What's the difference between a mask and a respirator' 	Carol Scholey
8	2 March 2016	<ul style="list-style-type: none"> • Revised title to take out Influenza heading • Expansion on symptom definition • Headed section for PPE with integral visor/ mask use • Added section on virology diagnostic testing • Added section with hyperlink to PHE Influenza Antiviral Prophylaxis and Treatment • Added section on the management of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) 	Julie Hartley

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1. INTRODUCTION

Respiratory infections are common, principally causing colds in both adults and children. Most are fairly mild, self-limiting and confined to the upper respiratory tract. However, these can progress and cause more severe infections and even death. There is a wide variety of viral causes of respiratory infection including rhinoviruses, respiratory syncytial virus (RSV), influenza viruses A, B and C, para-influenza viruses and coronaviruses. There are also newly emerging respiratory coronaviruses such as Severe Acute Respiratory Syndrome (SARS), Middle Eastern Respiratory syndrome (MERs) or more recently, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) commonly referred to as COVID-19, which resulted in a pandemic event in 2020.

2. PURPOSE

The purpose of this document is to provide concise guidance for all staff to minimize the potential risks of infection and to ensure prompt recognition of those patients who are at risk of infection. This document applies to all staff either employed or contracted within in-patient areas in Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

3. DUTIES AND RESPONSIBILITIES

This policy covers infection prevention and control management issues for Trust staff this includes:-

- Employees
- Volunteers
- Agency/Locum/Bank Staff
- Contractors whilst working on the Trust premises

Each individual member of staff, volunteer or contracted worker within the Trust is responsible for complying with the standards set out in the Policy to ensure that they adhere to best practice. They need to be aware of their personal responsibilities in preventing the spread of infection. It is the responsibility of Directors and Managers to ensure compliance with this standard.

4. INDIVIDUAL AND GROUP RESPONSIBILITIES

Seasonal influenza and Covid-19 vaccine is strongly recommended for all front line clinical staff on an annual basis. It is the responsibility of all front line clinical staff to access this service in order to minimise the risk to patients.

Trust Board

The Board, via the Chief Executive, is ultimately responsible for ensuring that systems are in place that effectively manages the risks associated with Infection Control. Their role is to support the implementation of a Board to Ward culture to support a Zero Tolerance approach to Health Care Associated Infections.

Director of Infection Prevention and Control: Is responsible for the development of infection and prevention and control strategies throughout the Trust to ensure best practice.

The Director of Infection Prevention and Control will provide assurance to the board that effective systems are in place.

Division Directors, Associate Medical Directors and Assistant Directors of Nursing

Each Divisional management team is responsible for ensuring the policy is adhered to and for ensuring action is taken if staff fails to comply with the policy.

The Infection Prevention and Control Team: is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required.

Heads of Nursing & Matrons: are responsible for ensuring implementation within their area by undertaking regular audits in ward rounds activities. Any deficits identified will be addressed to comply with policy.

Ward and Department Managers: are responsible for ensuring implementation within their area and for ensuring all staff who work within the area adhere to the principles at all times.

Consultant Medical Staff: are responsible for ensuring their junior staff read and understand this policy, and adhere to the principles contained in it at all times.

On-call Managers: are responsible for providing senior and executive leadership to ensure implementation of this policy.

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances, staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner, which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

5. KEY POINTS

Infected healthcare workers and visitors are potential sources of infection by respiratory viruses. Influenza and COVID-19 vaccine is recommended for all front line clinical staff each year as stipulated by the Department of Health to reduce risk of staff to patient transmission.

Infection can be acquired by direct and indirect contact and the airborne route. Transmission occurs from person to person by close contact, predominantly by large droplet/airborne respiratory secretions and /or contamination of hands. Standard infection control precautions (SICPs) and respiratory protective equipment (RPE) must be adhered to at all times.

High levels of community transmission and the co-circulation of respiratory viruses, such as COVID-19, influenza, RSV and others can increase pressure on healthcare systems.

Symptoms of Covid-19, flu and common respiratory infections include:

- Continuous cough
- High temperature, fever or chills
- Loss of, or change in, your normal sense of taste or smell
- Shortness of breath
- Unexplained tiredness, lack of energy
- Muscle aches and pains that are not due to exercise
- Not wanting to eat or not feeling hungry
- Headache that is unusual or longer lasting than usual
- Sore throat, stuffy or runny nose
- Diarrhoea, feeling sick or being sick

[People with symptoms of a respiratory infection including COVID-19 - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

Visitors with symptoms of respiratory infection must be discouraged from visiting. Face coverings – fluid resistant surgical masks (FRSM) to be encouraged if appropriate during outbreak situations or if visiting a patient with a known respiratory virus.

6. WHAT TO DO IF YOU HAVE A PATIENT WITH SUSPECTED VIRAL RESPIRATORY INFECTION

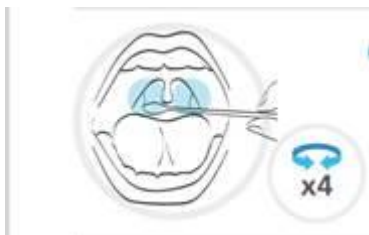
The purpose of this policy is to ensure that all staff within Doncaster & Bassetlaw Teaching Hospital take prompt action in the management of any patient identified (or suspected) of having a respiratory tract infection (RTI), by implementing general principles of infection prevention and control. During normal working hours advice must be sought from the Infection Prevention and Control Team (IPCT) on actions to be implemented, including isolating patients. Out of hours, advice must be sought from the on call Consultant in Infection. Please note that clinical care must not be compromised and discharge planning and services should continue, for

example Dieticians, Therapies, Integrated discharge and Nursing home assessments can be undertaken during the acute phase of a RTI. Any patient admitted with a suspected virus such as influenza, RSV or COVID-19 must be nursed immediately in a single room.

During an outbreak or epidemic it may be necessary to cohort nurse symptomatic patients with the same RTI. Obtain relevant investigation to confirm illness at the earliest opportunity, including use of point of care testing (POCT) for influenza A & B, also RSV in children, and COVID-19, a viral/polymerase chain reaction swab (PCR swab) to be sent to the laboratory for confirmation of diagnosis.

7. VIROLOGY DIAGNOSTIC TESTING

To test for influenza or other respiratory viruses **in adults** a green viral swab must be taken from the throat/nose. POCT can also be used for influenza, COVID-19 and RSV, take a swab from throat/nose. Staff must wear appropriate PPE including gloves, apron, face and eye protection when obtaining a swab.



Take the swab. Take green virology swab and gently rub it against the back of the throat on the area near the tonsils. This ensures that a proper sample in the area is captured well onto the swab, guide the swab downwards.

<https://assets.publishing.service.gov.uk/media/61d702c4d3bf7f0550c0c3be/COVID-19-self-test-throat-and-nose-instructions.pdf>

In children to test for respiratory viruses a nasopharyngeal swab or aspirate is taken (commonly for RSV). The viral medium is in a green swab. POCT is also available for Influenza, COVID-19 and RSV.

Nasopharyngeal Aspirate Specimen Collection:

Insert tubing attached to syringe (or compressed bulb for infants) through nose and direct towards nasopharynx. Pull back on syringe (or decompress bulb for infants) to withdraw secretions. Expel secretions into viral transport media.

This process also used for nasopharyngeal swabs for COVID-19 detection, swabbing the throat first and proceeding to the nostrils.



Nose swab. Take a nose swab using a dry swab and insert into both nostrils. Wear PPE – Apron, gloves, face mask and eye protection. Do not exert too much force.

8. MANAGEMENT OF A PATIENT WITH VIRAL RESPIRATORY INFECTION

8.1 Respiratory Isolation

The patient must be nursed in a single room or cohort bay with the doors closed. Continue isolation for 7-14 days after the onset of clinical symptoms or until the patient is asymptomatic, if symptoms persist longer than 7-14 days isolation must be continued until these resolve. N.B. immunocompromised patients' may excrete viruses for a longer period; discuss management with the physician in charge of patient care and with IPCT/Consultants of Infection.

Staff contact should be kept to a reasonable minimum without compromising patient care.

Effective hand hygiene before and after patient contact or contact with the patients' immediate environment. Please refer to the Trust PAT/IC 5 Hand Hygiene Policy.

See **Appendix 3** for tabled guidance at a glance for patients with Respiratory Illnesses.

8.2 Respiratory Hygiene/Cough Etiquette

Actively encourage patients to cover their nose and mouth with disposable tissues when coughing, sneezing, wiping or blowing their nose and dispose of the tissue in a disposal bag on the bedside prior to be disposed of as clinical waste.

For patients with a respiratory illness, encourage the wearing of a FRSM if the patient is tolerated to be transported around the hospital for an investigation e.g. Xray. To prevent spreading and contamination of the environment.

Encourage/assist the patient to clean their hands after coughing, sneezing, wiping or blowing their nose.

Restrict patient movement unless clinically indicated, if they need to travel to other areas within the hospital they should wear a FRSM if tolerated, at all times.

8.3 Personal Protective Equipment (PPE)

Health care workers delivering direct patient care must wear personal protective equipment (PPE):

- An integral combined visor and mask, FRSM plus visor or goggles must be worn to protect from the risk of contamination by splashes, aerosols and droplets. These can be worn separate if not available, FRSM plus full face visor. **See Appendix 1.**

- A FFP3 mask (Filtering Face Piece) to be selected if highly infectious (SARs, MERs, COVID-19) patient is having an aerosol generating procedures (AGP). See below point 8.4 .
- A disposable apron must be worn whenever there is a risk of contamination by a patient's blood or bodily fluids and during activities that involve close patient contact.
- Long sleeved fluid repellent gowns must be worn if there is risk of excessive soiling or contamination from AGP's.
- Disposable gloves must be worn when in direct contact with blood and body fluids including mucus.

8.4 Disposable Respirators (FFP3) for Aerosol Generated Procedures (AGP)

A filtering face piece (FFP mask) must be considered when a patient is admitted with a known/suspected COVID-19 infection, if they require AGPs.

To wear a FFP3 respirator you must first be fit tested and fit checked to an approved standard to safely wear this item of RPE. Please follow Trust guidance on where to access fit testing.

The decision to wear an FFP3 respirator should be based on clinical risk assessment, eg, task being undertaken, the presenting symptoms, the infectious state of the patient, risk of acquisition and the availability of treatment for the infectious agent.

AGPs are medical procedures that can result in the release of aerosols from the respiratory tract. The criteria for an AGP are a high risk of aerosol generation and increased risk of transmission (from patients with a known or suspected respiratory infection such as COVID-19).

The list of medical procedures that are considered to be aerosol generating and associated with an increased risk of respiratory transmission is:

- **awake* bronchoscopy** (including awake tracheal intubation)
- **awake* ear, nose, and throat (ENT)** airway procedures that involve respiratory suctioning
- **awake* upper gastro-intestinal endoscopy**
- **dental procedures** (using high speed or high frequency devices, for example ultrasonic scalers/high speed drills)
- **induction of sputum**
- **respiratory tract suctioning****
- **surgery or post-mortem procedures** (like high speed cutting / drilling) likely to produce aerosol from the respiratory tract (upper or lower) or sinuses
- **tracheostomy procedures** (insertion or removal).


*Awake including 'conscious' sedation (excluding anaesthetised patients with secured airway).

** The available evidence relating to respiratory tract suctioning is associated with ventilation. In line with a precautionary approach, open suctioning of the respiratory tract regardless of association with ventilation has been incorporated into the current AGP list. Only open suctioning beyond the oro-pharynx is currently considered an AGP. Oral/pharyngeal suctioning is **not** considered an AGP.

[NHS England » Chapter 2: Transmission based precautions \(TBPs\)](#)

8.5 Linen

Linen must be treated as infected by placing it in a red soluble bag inside a white plastic bag tied and sealed at the point of use.

<p>Infected linen</p>	<p>All used and soiled linen including patient wear from patients with known infections or suspected infectious.</p>	<p>Put in to a red soluble (alginate) bag and tie, then into a WHITE polythene bag</p> <p>CFPP 0104 states the outer bag must be tied and secured around the neck of the bag with tape which indicates 'Infected linen'</p>	<p>Red Soluble Bag <i>Inside a White Polythene Bag</i></p>	
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8.6 Environmental Cleaning

All floors and flat surfaces must be cleaned twice daily with the recommended disinfectant. Communal clinical equipment must be cleaned after each use.

An Isolation door notice must be displayed at all times. The door to the isolation room **must** remain closed at all times.

8.7 Ending Isolation

Isolation of the patient may be discontinued after 7-14 days from the onset of clinical illness providing symptoms are no longer present, if symptoms persist for longer than 7-14 days isolation should be continued until these resolve.

N.B. Immunocompromised patients (and children) may excrete viruses for a longer period. The IPC team may be contacted for advice.

9. INFLUENZA ANTIVIRAL TREATMENT AND PROPHYLAXIS

For the latest United Kingdom Health Security Agency (UKHSA) guidance on the use of antiviral agents for the treatment and prophylaxis of influenza and COVID-19, please access the internet,

<https://assets.publishing.service.gov.uk/media/62209cd38fa8f549097b87ec/ukhsa-guidance-antivirals-influenza-11v4.pdf>

10. STAFF VACINATION

Seasonal influenza and COVID-19 vaccine is strongly recommended for all front line clinical staff on an annual basis. It is the responsibility of all front line clinical staff to access this service in order to minimise the risk to patients.

11. VISITORS

All visitors with symptoms of respiratory disease should be discouraged from visiting. If the visitor needs to visit due to their relative being seriously ill or for compassionate reasons, ask the visitor to wear a FRSM to protect other patients and staff from illness. **(Appendix 2)**

12. TRAINING/ SUPPORT

The training requirements of all staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead or nominated person.

IPC must be included in individual Annual Development Appraisal and any training needs for IPC addressed.

Staff will receive instructions and direction regarding infection prevention and control practice and information from a number of sources:-

- Trust Policies and Procedures available on the intranet
- Infection Prevention & Control web-site on the intranet
- Ward/departmental/line managers
- As part of the mandatory SET training.
- Infection Prevention and Control Educational displays/ posters
- Trust Infection Prevention and Control Team
- Ward link practitioners
- UKHSA website

13. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

It is the responsibility of all department heads/professional leads to ensure that the staff they manage adhere to this policy. The Infection Prevention and Control Team will review this policy in the following circumstances:-

- When new national or international guidance are received.
- When newly published evidence demonstrates need for change to current practice.
- Every three years routinely.

Incidents where non-compliance with this policy is noted and are considered an actual or potential risk should be documented on an Adverse Incident and near miss report form.

Monitoring	Who	Frequency	How Reviewed
This policy will be reviewed in the following circumstances:-	APD Process Group. The Infection Prevention and Control Practitioners	Every three years routinely, unless: <ul style="list-style-type: none"> • When new national or international guidance are received. • When newly published evidence demonstrates need for change to current practice. • Action required from a Hot debriefing review or Serious Incident Investigation Report 	Approved Procedural Document (APD) database Policy will be approved and ratified by the Infection Prevention and Control Committee
Compliance with policy to negate cross-infection	The Infection Prevention and Control Practitioners	Weekly	“Alert organism review” to monitor adherence with the policy.
Effective hand hygiene	Hand hygiene audits completed by ward/ department staff. Infection Prevention and Control Practitioners.	Monthly	Deficits identified will be addressed via agree action plan to comply with policy.
Environmental cleanliness	Audits completed by Facilities teams and IPC environmental audits	According to risk category for each ward/ department Annually by the Infection Prevention and Control Practitioners	Deficits identified will be addressed via agree action plan to comply with policy.
Room cleaning check list	Isolation checklist completed by facilities service worker	Daily/twice daily while isolation required	Cleaning checklist outside patients room

14. DEFINITIONS

URTI – Upper Respiratory Tract Infection
 RSV – Respiratory Syncytial Virus
 SARs – Severe Acute Respiratory syndrome
 MERS – Middle Eastern Respiratory Syndrome
 SICPs – Standard Infection Control Precautions
 RPE – Respiratory Protective Equipment
 FRSM – Fluid Resistant Surgical Mask
 FFP3 respirator – Filter Face Piece Respirator Mask
 RTI – Respiratory Tract Infection
 IPCT – Infection Prevention & Control Team
 POCT – Point of Care Test

PCR – Polymerase Chain Reaction

PPE – Personal Protective Equipment

AGP – Aerosol Generating Procedures e.g. intubation.

COVID-19 - severe acute respiratory syndrome **coronavirus 2** (SARS-CoV-2)

15. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (**Appendix 4**).

16. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

PAT/IC 5 - [Hand Hygiene](#)

PAT/IC 16 – [Isolation Policy](#)

PAT/IC 19 – [Standard Infection Prevention and Control Precautions Policy](#)

PAT/IC 21 – [Laundry Policy – Bagging Procedure for Linen](#)

PAT/IC 24 – [Cleaning and Disinfection of Ward based Equipment Policy](#)

PAT/PA 19 - [Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards \(DoLS\)](#)

PAT/PA 28 - [Privacy and Dignity Policy](#)

17. DATA PROTECTION

Any personal data processing associated with this policy will be carried out under ‘Current data protection legislation’ as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website:

<https://www.dbth.nhs.uk/about-us/our-publications/information-governance/>

18. REFERENCES

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007 (last updated October 2020)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

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UKHSA. (2023, November). *UKHSA annual business plan: 2023 to 2024*. GOV.UK. <https://www.gov.uk/government/publications/ukhsa-business-plan-2023-to-2024/ukhsa-annual-business-plan-2023-to-2024>



APPENDIX 1

WHEN TO USE A SURGICAL FACE MASK OR FFP3 RESPIRATOR



When to use a **surgical face mask** or **FFP3** respirator

When caring for patients with **suspected or confirmed infectious respiratory virus**, all healthcare workers need to – prior to any patient interaction – assess the infectious risk posed to themselves and wear the appropriate personal protective equipment (PPE) to minimise that risk.

When to use a surgical face mask		When to use an FFP3 respirator
		
In cohorted area (but no patient contact)	Close patient contact (within one metre)	<ul style="list-style-type: none"> Carrying out potentially infectious aerosol generating procedures
For example: Cleaning the room, equipment cleaning, discharge patient room cleaning, etc	For example: Providing patient care, direct home care visit, diagnostic imaging, phlebotomy services, physiotherapy, etc	For example: bronchoscopy, endotracheal intubation, tracheostomy procedures, cardiopulmonary resuscitation, diagnostic sputum induction.
PPE to be worn	PPE to be worn	<ul style="list-style-type: none"> Where a patient is known/suspected to have an infection spread via the aerosol route When caring for patients known/suspected to be infected with a newly identified infectious respiratory virus
<ul style="list-style-type: none"> Surgical face mask (along with other designated PPE for cleaning) 	<ul style="list-style-type: none"> Surgical face mask Apron Gloves Eye protection (if risk of contamination of eyes by splashes or droplets) 	PPE to be worn <ul style="list-style-type: none"> FFP3 respirator Gown Gloves Eye protection
		<ul style="list-style-type: none"> Fit testing should be carried out by a properly trained competent fit tester. Other guidance is available on bacterial infections and pulmonary tuberculosis

These images are for illustrative purposes only. Always follow the manufacturer's instructions.

Remember

- PPE should be put on and removed in an order that minimises the potential for cross-contamination.
- The order for PPE removal is gloves, apron or gown, eye protection, surgical face mask or FFP3 respirator.
- Hand hygiene must always be performed following removal of PPE.
- Healthcare workers who have had influenza vaccination, or confirmed influenza infection, are still advised to use the above infection control precautions.

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APPENDIX 2

COUGHS AND SNEEZES SPREAD DISEASES



Coughs and sneezes spread diseases



always carry
tissues



cover your
coughs and
sneezes



throw used
tissues in
a bin



always clean
your hands

Stop germs spreading

Organism	Route of transmission	Period of infectivity	Isolation precautions	Comments
Adenovirus	Respiratory droplets and secretions	Mild respiratory illness	No	Can cause conjunctivitis particularly amongst children
Bronchiolitis (infants)	Respiratory droplets and direct contact with secretions	While symptomatic (5 days or longer)	Yes	Commonly caused by respiratory viruses (e.g. RSV, parainfluenza)
Corona viruses (e.g. COVID19, SARS, MERS)	Respiratory droplets and direct contact with secretions	While symptomatic (approx. 7 days)	Yes	Wear FRSM or FFP3 mask if undertaking AGPs (see NHS guidance for considerations)
Influenza A & B	Respiratory droplets and direct contact with secretions	While symptomatic (generally 5-7 days)	Yes	Wear FRSM with visor to protect mucus membranes. Tamiflu generally reduces the symptoms quicker.
Respiratory syncytial virus (RSV)	By direct contact with respiratory secretions or droplets	While symptomatic	Yes	Highly transmittable on paediatric wards
Rhinovirus	Respiratory droplets and secretions	Mild respiratory illness	No	Common cold

Reference: 1. A-Z of Pathogens. NHS England.

APPENDIX 4 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Division/Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
The Management of Respiratory Influenza Type Viruses.	Corporate Nursing, infection Prevention & Control	Carol Scholey, Infection Prevention & Control Practitioner.	Existing Policy	June 2024
1) Who is responsible for this policy? Infection Prevention & Control Team				
2) Describe the purpose of the service / function / policy / project/ strategy? Policy Updated using the latest evidence to promote the screening and management of respiratory type viruses				
3) Are there any associated objectives? Public Health England Policy				
4) What factors contribute or detract from achieving intended outcomes? Nil				
5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No				
<ul style="list-style-type: none"> If yes, please describe current or planned activities to address the impact [e.g. Monitoring, consultation] 				
6) Is there any scope for new measures which would promote equality? [any actions to be taken]				
7) Are any of the following groups adversely affected by the policy?				
Protected Characteristics	Affected?	Impact		
a) Age	No	Neutral		
b) Disability	No	Neutral		
c) Gender	No	Neutral		
d) Gender Reassignment	No	Neutral		
e) Marriage/Civil Partnership	No	Neutral		
f) Maternity/Pregnancy	No	Neutral		
g) Race	No	Neutral		
h) Religion/Belief	No	Neutral		
i) Sexual Orientation	No	Neutral		
8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box				
Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4	
Date for next review:				
Checked by: Miriam Boyack			Date: June 2024	